

ASSUMPTION OF RISK AND WAIVER OF CLAIMS FOR ADULT STUDENTS

STUDENT: (Name and Address)

INSTITUTION:

The University of Texas Health Science Center at Houston -
McGovern Medical School

DESCRIPTION OF ACTIVITY OR TRIP: Pre-JAMP Symposium at McGovern Medical School

Activities in the SCSC and Gross Anatomy Lab, Medical School Campus and Memorial Hermann Hospital Tour

LOCATION: TBD

DATE: April 21, 2022

I, the above named student, am eighteen years of age or older and have voluntarily applied to participate in the above Activity or Trip. I acknowledge that the nature of the Activity or Trip may expose me to hazards or risks that may result in my illness, personal injury or death and I understand and appreciate the nature of such hazards and risks.

In consideration of my participation in the Activity or Trip, I hereby accept all risk to my health and of my injury or death that may result from such participation and I hereby release the above named Institution, its governing board, officers, employees and representatives from any liability to me, my personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result from or occur during my participation in the Activity or Trip, whether caused by negligence of the Institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in the described Activity or Trip.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE AN ASSUMPTION OF RISK AND WAIVER OF ALL CLAIMS AND CAUSES OF ACTION FOR MY INJURY OR DEATH OR DAMAGE TO MY PROPERTY THAT OCCURS WHILE PARTICIPATING IN THE DESCRIBED ACTIVITY OR TRIP AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY MY NEGLIGENT OR INTENTIONAL ACT OR OMISSION.

Signature of Participant

Date

Witness

Date



Release Form for Adults

I have authorized The University of Texas Health Science Center at Houston (“UTHealth”) or its agents or affiliates to obtain, retain and/or release, in its sole discretion, any and all “Media Images” of me (audio or video interview or other recording, and/or photograph and/or illustration) , including information and/or materials in the Media Images regarding my personal and/or medical history, condition(s), and treatment(s) for the purposes of publicizing, promoting, marketing, or advertising UTHealth’s activities, programs, and services.

I hereby release UTHealth and its agents and employees, and The University of Texas System and its Regents, officers, agents and employees from any and all liability connected with the capture or use of any and all Media Images referenced in the Media Authorization Form for Adults.

I hereby voluntarily waive all rights, interest or claims for payment in connection with any capture or use of any and all Media Images.

If I withdraw my authorization for the capture, use or disclosure of Media Images, this Release will remain in full force and effect.

Name	Signature			
<hr/>				
Address	City	State	Zip Code	Telephone
Media Event: _____			Date: _____	